BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT L. BERRY, M.D.** Holder of License No. **23069** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No: MD-03-1232A** **MD-04-0523A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") at an emergency Board meeting on February 10, 2005. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against Robert L. Berry's ("Respondent") license. Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearings or other Board action. A.R.S. § 32-1451.02(B).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 23069 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-1232 on November 25, 2003 after receiving notification from the State of Washington that Respondent, a Washington licensee, was under investigation for possible unprofessional conduct involving the care of a particular patient as well as other issues of unprofessional conduct.

4. The Board initiated case number MD-04-0523A after receiving notification from the State of Washington that it had summarily suspended Respondent's license on March 17, 2004 in order to protect the pubic health and safety. The Washington State Order is attached and incorporated by reference.

5. The Board is required to summarily suspend the license of its licensee if a medical board in another jurisdiction has done so because of its belief that the public health, safety or welfare imperatively required emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 23069 for the practice of allopathic medicine in the State of Arizona.

2. The Board shall order the summary suspension of a license pending proceedings for revocation or other action if a medical regulatory board in another jurisdiction in the United States has taken the same action because of its belief that the public health, safety or welfare imperatively required emergency action. A.R.S. § 32-1451.02(B).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 23069, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him.

Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 10 day of February, 2005.

ARIZONA MEDICAL BOARD

(SEAL)

By: _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of February, 2005, with:

The Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Executed copy of the foregoing mailed by Certified Mail this 10th day of February, 2005, to:

Robert L. Berry, M.D.
Address of Record

Executed copy of the foregoing mailed by First Class mail this 10th day of February, 2005, to:

Dean Brekke
Assistant Attorney General
Arizona Attorney General's Office
1275 West Washington, CIV/LES
Phoenix, AZ 85007

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of:	)	Docket No. 04-03-A-1016MD
ROBERT LEE BERRY, M.D., License No. MD00040586,	)	EX PARTE ORDER OF SUMMARY ACTION
Respondent.	)	

This matter came before the Medical Quality Assurance Commission, (the Commission), on March 15, 2004, by an Ex Parte Motion for Order of Summary Action brought by the Department of Health (the Department) by and through its attorney, Kim O'Neal, Assistant Attorney General. The Presiding Officer for the Commission was Senior Health Law Judge Lyle O. Hanson. The Commission members deciding the Ex Parte Motion for Order of Summary Action were: Chelle Moat, M.D, Panel Chair; Douglas Yoshida, M.D.; and Cabell Tennis, JD. The Commission, having reviewed the motion and the documents submitted in support of the motion, hereby enters the following:

I. ALLEGATIONS

1.1 On September 30, 2001, Robert Lee Berry, M.D., (the Respondent), applied for a license to practice as a physician and surgeon in Washington, and was issued a license to practice as a physician and surgeon on November 1, 2001. The Respondent was licensed at all times material to this matter.

1.2 The Respondent practiced as a locum tenens anesthesiologist at Kadlec Medical Center in Richland, Washington during the period of time reflected in the following allegations.

1.3 Patient One was a [redacted]-year-old G5P3 who had delivered an 8 pound 3 ounce female infant at 0915 on November [redacted] 2002, at Kadlec Medical Center.

1.4 On November [redacted], 2002, the Respondent was scheduled to provide anesthesia for five surgery cases. Patient One was the fifth surgery case, and was scheduled for a tubal ligation and umbilical hernia repair on this day. Patient One was brought to the operating room just before 1500.

1.5 Prior to initiating anesthesia, the Respondent incorrectly filled out the patient's pre-anesthetic assessment. He listed bee stings as an allergy to medication; he did not to list the patient's weight, height, vital signs, lab work, and whether or not she had any prior anesthetic complications. He did not note her scheduled surgery.

1.6 The Respondent initiated anesthesia to Patient One at 1524. He used Fentanyl, Versed, Propatyl and Rocurium. He estimated that Fentanyl and Rocurium, (paralytic agents), would last approximately 30 minutes.

1.7 Patient One was connected to and monitored by ECG, heart rate, pulse oximetry, and blood pressure machines. A Solar 800M pulse oximetry machine was available and capable of providing a printout of her blood pressure, pulse, and percent of oxygen saturation.

1.8 During the course of the procedure, the Respondent did not monitor and document the patient's blood pressure, heart rate, respirations, and oxygen saturation.

1.9 At 1530 Patient One's heart rate as indicated by the pulse oximetry machine was 42, and her blood pressure was 99/70. The alarms on the pulse oximetry machine had been turned off. The Respondent did not ensure that the alarms were turned on.

1.10 The Respondent's anesthesia record lists the blood pressure at 1530 as 130/70. He subsequently admitted that his record was created after Patient One coded and was not accurate.

1.11 At 1534 Patient One's surgery was completed and a dressing was placed over her incision. About this time Respondent gave the Patient 100 mg of Demerol in anticipation of the end of surgery despite the fact that the Fentanyl was still in effect.

1.12 The Respondent extubated the patient at about 1534. The Respondent claims that he gave her Neostigmine to reverse the paralytics. However, there is no record that Patient One was given Neostigmine on the anesthesia record or the billing record.

1.13 At 1535 Patient One's heart rate was 66, and her blood pressure was 76/39. The Respondent did not note her hypotension or effectively relate to it. He removed the patient's ECG leads and her blood pressure cuff.

1.14 Subsequently, the Respondent noted that the waveform on the pulse Oximetry machine was abnormal. He asked the nurse to check her pulse oximeter monitor. The nurse noted that the patient's fingers were blue, that she had no pulse, and she was not breathing.

1.15 The Respondent did not immediately call a code but reapplied the ECG leads. At 1540 the pulse oximetry recorded no heart rate, a mean blood pressure of 25, and no oxygen saturation.

1.16 CPR was administered to Patient One at 1541. The Respondent intubated the patient at 1543. Although she was resuscitated, she sustained severe anoxic brain injury that resulted in her remaining in a vegetative state.

1.17 The Respondent failed to capably administer appropriate anesthesiology to Patient One and to capably monitor Patient One's vital signs during her surgery. Nor did Respondent capably relate to her anesthesia event that resulted in severe brain damage.

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1.18 The Respondent's Washington license application, submitted by him about September 30, 2001, shows that he indicated a "no" answer to all the personal data questions that relate to current use, including illegal use, of chemical substances that would impair the applicant's ability to practice medicine.

1.19 The Respondent provided "no" answers to Questions 1, 2, and 4, regardless of his receiving a letter, on or about March 27, 2001, from his previous anesthesiology group in Louisiana that admonished him for reporting to work on several occasions impaired and unable to perform his duties.

1.20 The Respondent concealed a material fact in making application for a license.

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1.21 In June 2002, the Respondent was involved in a vehicular accident while serving as a locum tenens at a Montana hospital. He sustained injuries resulting in [redacted]

1.22 On the day of Patient One's surgery, nursing staff noted that the Respondent looked ill and appeared diaphoretic and congested.

1.23 On November 14, 2002, the Respondent admitted to the hospital administration that he diverted Demerol from patients. [redacted]

1.24 The Respondent was currently misusing controlled substance drugs during this period.

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1.25 Kadlec Medical Center uses a Pyxis medication dispensing system that tracks who withdraws a particular medication in preparation for dispensing it to a designated patient. This system was in effect during the period of time of Patient One's surgery and also during the time relating to the following patients.

1.26 Kadlec anesthesiologists carry around and use a "tackle box" that contains controlled substances, which they are required to "log out" from the pharmacy.

1.27 During Respondent's locum tenens service to Kadlec he employed these systems. The Pyxis system and the "tackle box" system reflect data that Respondent withdrew seventy-five 100mg injections from Pyxis portals during the 15 days he worked in the month of October, 2002, as compared to an average of 3 injections withdrawn by Respondent during the prior seven month period.

1.28 The Respondent's withdrawal data for anesthesia medications, predominantly Demerol, do not reconcile with the medical records of the following patients for whom the medication was given.

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1.29 On November 12, 2002, Patient Two, a [redacted] year-old male, presented at Kadlec Medical Center for a radical prostatectomy. The Respondent provided anesthesia for this procedure.

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1.30 When Patient Two was taken to the recovery room at 1023, his Aldrete score was poor and indicated his level of consciousness as unresponsive on arrival.

1.31 The Pyxis system data reflected that the Respondent withdrew Demerol for Patient Two but the patient already had a PCA pump placed for pain control.

1.32 The medications the Respondent withdrew from the Pyxis system and his tackle box do not reconcile with what was listed as being administered to Patient Two.

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1.33 On November 12, 2002, Patient Three, a [redacted] year-old 195-pound male, was admitted for a cystoscopy and transurethral resection of the prostate. The Respondent provided anesthesia for the patient's surgery.

1.34 The Respondent did not record the wastage of the previously drawn Fentanyl for Patient Three after giving him only 100 micrograms.

1.35 The Respondent's handwriting is illegible, and the amount of medications he withdrew from the Pyxis system and his tackle box for this patient do not reconcile with what was listed as being administered to Patient Three.

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1.36 On November 12, 2002, Patient Four, an [redacted] year-old male, was admitted for a cystoscopy. He presented with dementia, hypertension, diabetes, renal insufficiency, and was undergoing elevated liver function studies.

1.37 The Respondent did not capably and appropriately indicate the type of anesthesia he provided, (he circled "anesth" as opposed to general or MAC), to Patient Four. He did not record if Patient Four had an ET tube in place. He did not record the

pre-anesthetic assessment, the patient's vital signs at the beginning of the procedure, and he did not list the procedure to be performed.

1.38 His writing in the chart was illegible. The Respondent recorded the anesthesia end time as "98/58" rather than indicting a time.

1.39 When Patient Four presented to the recovery room he was unable to move and was dyspneic. His Aldrete score was 3. Patient Four had to be given Romazicon and Narcan to counteract his sedation.

1.40 The medications the Respondent withdrew from the Pyxis system and from his tackle box do not reconcile with what was listed as being administered to Patient Four.

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1.41 On November 12, 2002, Patient Five, a [redacted] year-old female, G3P3, was scheduled for a tubal ligation. Her surgery started about 1345.

1.42 The Respondent did not perform and document any pre-anesthetic assessment. The Respondent did not document the patient's vital signs and the times of dosage on the anesthesia record.

1.43 Patient Five was transferred to the recovery room and had an Aldrete score of 7. She was tachypneic, sedated, and restless.

1.44 The Respondent's record is illegible and the medications he withdrew for Patient Five from the Pyxis system and his tackle box do not reconcile with what was listed as being administered to Patient Five.

1.45 The Respondent failed to appropriately assess and monitor these patients during the course of their surgeries. The amounts of the medications the Respondent

withdrew from the Pyxis system and his tackle box did not reconcile with the amounts of medications listed as being administered to these patients. The Respondent did not record or account for the wastage or excess of these medications.

1.46 The Respondent inappropriately managed the administration of the anesthesia for these patients putting them at an unreasonable risk of harm, and diverted some of their medications.

II. FINDINGS OF FACT

2.1 The Respondent was licensed by the State of Washington at all times applicable to this matter and practiced in Richland, Washington.

2.2 The Commission issued a Statement of Charges alleging the Respondent violated RCW 18.130.180(4), (2), [redacted] The Statement of Charges was accompanied by all other documents required by WAC 246-11-250.

2.3 The Commission finds that the public health, safety and welfare imperatively require emergency action pending further proceedings due to the nature of the allegations as stated above and in the Statement of Charges.

2.4 The alleged conduct, as set forth in the Allegations above and as supported by the documents attached to the Declaration supporting the Ex Parte Motion for Order of Summary Action, is directly related to Respondent's ability to practice medicine and surgery in the state of Washington. The Commission finds, based on the declaration and evidence submitted with the Ex Parte Motion for Order of Summary Action, that a summary suspension of Respondent's license to practice medicine and surgery is only

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such action as is necessary to prevent or avoid immediate danger to the public health, safety, or welfare.

III. CONCLUSIONS OF LAW

3.1 The Commission has jurisdiction over Respondent's license to practice medicine and surgery.

3.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4), RCW 34.05.479, RCW 18.130.050(7), and WAC 246-11-300.

3.3 The above Findings of Fact and Allegations establish:

(a) The existence of an immediate danger to the public health, safety, or welfare;

(b) That the requested summary action adequately addresses the danger to the public health, safety, or welfare; and

(c) The requested summary action is necessary to address the danger to the public health, safety, or welfare.

3.4 The requested summary action is the least restrictive agency action justified by the danger posed by the Respondent's continued practice of medicine and surgery.

3.5 The above Findings of Fact and Allegations establish conduct which warrants summary action to protect the public health, safety, or welfare.

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IV. ORDER

Based on the above Findings of Fact, Allegations and Conclusions of Law, the Commission enters the following order: IT IS HEREBY ORDERED that the license of Respondent be SUMMARILY SUSPENDED pending further disciplinary proceedings by the Commission.

Dated this 16 day of March, 2004.

Chelle L - Moat MD.

CHELLE MOAT, M.D.
Panel Chair

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Program Nos. 2003-07-0073 and 2003-10-006